Touro
LCMC Health

SURGERY RESERVATION

PAGE 1 OF 1

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

PHONE: 504-897-8438 FAX: 504-897-7853

Booking Case #_____

Request Surgery Date: 01/01/2024 Time/Length of Procedure: hours/mins

Request Pre-Op Appointment Date:_____ Time:_____

Please Call 504-897-7771 to Schedule a Pre-Op Appointment. If Not Requested Above

Patient Name: NAME DOB: 01/01/19**

Patient SS#: xxx-xx-**** M/F: M/F MR#: 100******* RM#:_____

Address: ADDRESS

Patient Phone #: (***.)***.**** Patient Ins.:_____

Office Staff Name:_____ Office#: 504.988.5271 Fax#:_____

Surgeon Name: NAME, MD Assistant Surgeon:_____

Procedure 1. PROCEDURE CPT Code: ***

Procedure 2._____ CPT Code:_____

Procedure 3._____ CPT Code:_____

Procedure 4._____ CPT Code:_____

Please check all items/Equipment needed for Procedure:

	Stryker Video		Robotic # Arms
	Stryker Ortho		Docking Side: (Supine Prone)
	Gold Laser		Lithotomy
	CO2 Laser		Jack Knife
	Holmium Laser (Inhouse Vendor)		**Anesthesia:**
	Biomet	X	General
	Depuy		Mac
	Synthes		Spinal
	Fusion Navigation (Scan at Touro Scan on disc)		Epidural
	Neuromonitoring		Local
	Neoprobe (Inhouse Vendor)	X	Other:
	Medtronic Robtic SI		
	Robotic XI		

Admit Type: ___Inpatient X Outpatient/23hr. Stay ___AM Admit

Patient Diagnosis and ICD-10 Code: DIAGNOSIS

Instruments/Implants:_____

Please contact OR Material Coordinator for any special requests @ 897-7020

Printed Name of Hospital Representative:	Office #:	Fax #:
NAME		
Hospital Representative's Signature: X	**Date** MM/DD/YY / /	**Time** 00:00 AM/PM :

ENCOUNTER LEVEL

SURGERY RESERVATION

TI7423 | (03/18, 07/22) Revised

EL317